

SCHWARTZ

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

6719

State File No. 1766

FILED MAR 8 1950

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>1766</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (If deceased lived. If institution: residence before admission.) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>5-months</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Gardenville</b>		<b>484</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>7073 Fox Croft Drive</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Barbara</b> b. (Middle) <b>Schwartz</b> c. (Last) _____				4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 21, 1950</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>M.</b>		8. DATE OF BIRTH <b>April 26, 1890</b>		9. AGE (In years last birthday) <b>59</b> IF UNDER 1 YEAR Months <b>9</b> Days <b>25</b> IF UNDER 12 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>Anton Keller</b>		13b. MOTHER'S MAIDEN NAME <b>Unk. Goger</b>		14. NAME OF HUSBAND OR WIFE <b>Mr. Frank Schwartz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. John Printy, 7073 Fox Croft Drive</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Embolism</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cholecystitis for</b> DUE TO (c) <b>Cholecystitis + Cholelithiasis</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
19a. DATE OF OPERATION <b></b>		19b. MAJOR FINDINGS OF OPERATION <b>Cholecystitis + Cholelithiasis</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b></b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b></b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>384X</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <b></b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b></b>			
22. I hereby certify that I attended the deceased from <b>Jan 3, 1950</b> , to <b>Feb 21, 1950</b> , that I last saw the deceased alive on <b>Feb 20, 1950</b> , and that death occurred at <b>9:30 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>D. A. Munsch M.D.</b>				23b. ADDRESS <b>339 W. Main St. Clayton, Mo.</b>		23c. DATE SIGNED <b>2-23-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Feb. 24, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
DATE REC'D BY LOCAL <b>FEB 23 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Kasper</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Arthur J. Donnelly 3840 Lindell Blvd.</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. ....

Signed

*Thomas R. Fenwick*

Licensed Embalmer No. 3793

P. O. Address 3840 Lindell

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.